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An exploration of the mental health needs of asylum seeking women and children in the UK: implications for health visiting practice

Abstract

The aim of this article is to explore and to advance an understanding of the issues surrounding the mental health and wellbeing of asylum seekers in the UK as it relates to health visiting practice. This literature review will identify and evaluate literature on this subject area to facilitate the health visitor's understanding of working with asylum seekers. It will look at how better awareness of cultural differences can help health visitors improve how they meet the needs - in particular the mental health needs - of this client group. This article will then look at some recommendations that may reduce health inequalities, therefore having an influence on public health policies in the UK.

Health visitors need to understand the complexities of this client group to ensure the provision of appropriate robust care planning and signposting to relevant services. Many asylum seekers who enter the UK already have mental health problems including depression, anxiety and post-traumatic stress disorder. The mental health of asylum seekers in the UK can then further deteriorate due to difficulties in accessing health care through, for example, lack of understanding of the UK health and social

systems. Women and child asylum seekers are especially vulnerable as they are more likely to have experienced sexual exploitation, rape, trafficking, domestic abuse and neglect with a resultant impact on their physical and mental health.

Keywords

health visiting, asylum seekers, mental health, immigration, women, children

Introduction and Background

Many health visiting services in the UK have asylum seeking families on their caseload. These people may have fled war and persecution from their countries (Cowley et al, 2013) and may have experienced trauma and abuse, which could have an impact on their mental health (Freeman, 2007). In particular, asylum seeking families from the Middle East and Africa, are fleeing from the dangers of war and travelling to Europe. The current rates documented in 2015 found that the largest number of people entering the EU did so through Germany (1,460,00) and then UK (548,00), Spain (290,00) and Italy (250,00) (Hawkins, 2018). The trauma will have had a significant impact on their mental health and wellbeing (Soares and Tzafalias, 2015)

Mental health issues of asylum seeking women and their children in the UK

The main mental health problems of asylum seekers are reported to be depression, anxiety disorders and post-traumatic stress disorders (Keyes, 2000). Other risk factors that affect and exacerbate the symptoms of these mental health issues include poverty, poor education, low self-esteem and poor physical health (Woodward et al, 2016). There are also a number of behavioural consequences which may relate to immigrant poor mental health, including domestic violence and female genital

mutilation (FGM) (Woodward et al, 2016). Asylum seeking women are at particular risk of suffering from depression (Morgan et al, 2017).

Given the early 0-3 years are important years in a child's development, children who are exposed to traumatic events at this young age can experience psychological and emotional problems in adult life (Boyd and Bee (2009). Berger (1999) states that children require love and supportive interaction for emotional development. Therefore, children in situations contrary to this, which would include experiencing trauma - such as witnessing or experiencing physical or emotional abuse, violence and poverty - can be at higher risk of developing mental health and physical health problems (Boyd and Bee, 2009).

Traumatic recurring events in a child's life is known as toxic stress syndrome. Toxic stress can occur when a child is constantly being exposed to difficult and unpleasant situations. A child living in a war zone may see violence and traumatic events and this can result in severe consequences, such as delinquency, reduced intelligence, increased aggression, depression and affectionless psychopathy (Gronski et al, 2013). A health needs assessment can help the health visitor identify and address the toxic stress being endured by asylum seeking mothers and children (NICE, 2005). Most importantly, the health visitor needs to be attuned to the cultural needs and previous experiences of these families.

However, it may prove difficult for the health visitor to fully assess the care needs as families are often wary and may mistrust perceived authority figures as a result of their previous experiences. In addition, due to increased caseload pressures the health visitor may not have the time and resources to fully meet the needs of these vulnerable people.

Asylum seeking children who have no parents have a greater chance of developing mental health illness and disorders (Sanchez-Cao et al, 2012). If a person is constantly at a high level of stress and anxiety then this can cause long term psychological damage (Shonkoff and Fisher, 2013). Therefore, the health visitor needs to use their advanced communication skills to uncover the hidden emotional and psychological life of their clients using a person centred approach.

To support these families, and for care to be as effective as possible, health visitors need to listen and understand the families' needs whilst also being mindful of the traumatic previous experiences (Bennett-Levy et al, 2008). This involves supporting people to communicate their own needs, so that they can take back some control of their life, which can mean so much to someone who has lost everything (Martin and Carey, 2009).

Sara and Lappin (2017) suggest that childhood trauma is a major public health issue and it is clear that the health visitor is in an ideal position, as a leader in the early years of children and families services, to help. A universal health visiting service is available to all families and children, so they have the same opportunities to access health services to address their individual care needs. Health visitors take leading roles in the delivery and development of early intervention, and provide a link between families and other agencies (Department of Health, 2011). Children who have been exposed to constant levels of anxiety and stress may continue to have long term psychological damage into adulthood (Shonkoff and Fisher, 2013), so it is vitally important that the health visitor has a clear, early understanding of potential issues when undertaking health assessments so there is no delay in getting timely and correct support.

Perinatal mental health issues of women asylum seekers

The perinatal mental health of asylum women is another important consideration when exploring the needs of asylum seeking families and the relationship with their children. Asylum seeking women are at high risk of suffering from perinatal illness due to pre-existing poor mental health resulting from, for example, fleeing war and conflict (Edge, 2007). The impact of this can be evidenced in cases of poor attachment between a mother and her children when the mother is suffering from depression (Boyd and Bee, 2009).

In addition, asylum seeking women and their children can face social isolation as they find themselves in an unfamiliar country, which can hinder their integration into the local community.

A further consideration in relation to this, as reported by Edge (2007), is that most UK research on mental illness of black minority ethnic groups (BME) is based on severe and enduring mental illness, such as schizophrenia, and the focus is on men not women. Initial observations of the study highlight that little research has been conducted into BME women's mental health.

Social isolation and dearth of research poses a risk of asylum seeking women becoming invisible - therefore the health visitor and services are unaware of them - and their mental health needs go unaddressed (McKeary and Newbold, 2010). The problem then arises that women from vulnerable groups are unable to access and receive the appropriate health care interventions to support them and their children.

A study by Edge (2010) on BAME women (Black Asian Minority Ethnic) found that health professionals, including midwives and health visitors, felt antenatal depression did not warrant referral into mental health services. The reason given was that the

health professionals within the study lacked knowledge in mental health disorders, which meant they did not make appropriate referrals to mental health services.

The study also highlighted that care pathways in perinatal health were unclearly defined. Participants failed to identify women within this group who might be at risk of postnatal depression, even when there was a history of postnatal depression. The findings suggest that antenatal care focuses primarily on physical issues. It is clearly of concern that professionals are not identifying obvious risk factors pertaining to perinatal mental health within an already vulnerable group of women. One major concern raised by health professionals is that BME women are often moved at very short notice by the authorities to another part of the UK, but this is not communicated to the health professionals in a timely manner or, sometimes, not communicated at all. This can leave health visitors feeling that they have somehow let their clients down and not fulfilled their professional role and responsibilities (Reynolds and White, 2010).

The importance of recognising resilience and protective factors

Another factor to consider when supporting this client group is the strength and capacity of individuals and how recognition of resilience and protective factors can impact on successful health need outcomes.

Luthar (1993) describes resilience as a person's capacity to overcome difficulties and problems in their lives, despite the high risks that these problems pose in terms of emotional and psychological damage. Protective factors are defined as characteristics of the child, family, and wider environment that reduce the negative effects of adversity on child outcome (Masten and Reed, 2002).

Asylum seekers who have high resilience and protective factors may be able to cope more effectively with their previous experiences. This can enable them to positively move forward with their lives as evidenced by Panter-Brick et al (2014) who also identified the support of the wider family as being a crucial component. It is important for the health visitor to identify the protective factors of asylum seeking children and families (Mohamed and Thomas, 2017) because they can help achieve desirable outcomes even when the risk of mental health problems are high (Werner, 1989).

According to Betancourt and Khan (2008), research has grown on the mental health consequences on children of war. Measham et al (2014) suggest that children with individual characteristics - such as an easy going temperament, who are empathic, have a strong family bond and good coping skills - are more resilient children (Betancourt and Khan, 2008). Although there are concerns from NICE (2017) about how the mental health of a child can affect their emotional wellbeing in adulthood, encouragingly there is evidence that shows asylum seeking children do experience positive mental health outcomes and resilience, despite their difficult experiences (Measham et al, 2014).

Health visitors can play an important role in the early identification of low mood and mental health problems, and getting the support the family need in a timely manner. The health visitor facilitates this through undertaking a holistic health needs assessment and making appropriate referrals to other services - for example, stay and play sessions at a local children's centre, English classes, nursery provision, mental health services and charitable services within the community. Effective signposting and referrals to key services can help reduce social isolation, build community capacity and improve the wellbeing, health and education of this client group (Cabrera and Leyendecker, 2016)

Religion has also been highlighted to be an important source of protecting children from mental health problems and encouraging their resilience. Fernando (2011) found that children who followed Buddhist and Christian practices were able to cope more effectively in difficult circumstances and this promoted their wellbeing. In addition, environmental factors such as supportive adults and good community networks, which may include religious groups and religious communities, were important in promoting and sustaining resilience (Gorman-Smith and Tolan, 2003).

The importance of effective communication

Whilst resilience, protective factors and religion are all important considerations, communication and the extent to which communication and language issues are addressed is crucially important for health visitors.

Language and communication barriers appear to be key factors in poor healthcare interventions with asylum seekers. According to Briscoe and Lavender (2009), there is a human need for mutual understanding and meaningful communication. As they state: "Relying on a system where understanding is taken for granted may contribute to misinterpretation" (p.19).

Health visitors can use interpreters effectively by meeting prior to a client visit to discuss any key issues together. The interpreter may be an invaluable source of information about the culture and country of the asylum seeker. At the end of the visit the health visitor could also have a debriefing session with the interpreter which may be useful (Tribe, 2007).

However, it is not a solution to simply have an interpreter who speaks the language as there are some words and phrases in every language that cannot be directly

translated (Katan, 2004). Therefore, the health visitor needs to be aware that it is both the verbal word and cultural interpretation that is important when working with interpreters. This then enables the health visitor to embrace the differences of people in a holistic way and further supports the health visitor to undertake a good assessment of the client's needs (Mandel, 2009).

Being mindful of language problems, nonverbal communication is instrumental in enhancing partnership working with the health visitor and the caregiver whereby positive aspects can emerge (Ledema et al, 2015). Silverman et al (2013) and Norfolk et al (2007) discussed the importance of empathy in establishing a rapport in consultation with a patient. The health visitor can show nonverbal communication by showing empathic responses, such as smiling and nodding appropriately within, for example, listening visits with mothers and fathers who may be experiencing depression. Listening visits are defined as unstructured, client-led discussions, involving the health visitor using their active listening skills, reflection and providing empathic responses to parents who are suffering from mild to moderate depression and anxiety (NICE, 2015).

Building and enhancing therapeutic relationships

One of the key aims for the health visitor is to empower asylum seeking families and rebuild their self-esteem. It has been suggested that this can be achieved by the health visitor caring from the "heart and not from the mouth" (Campinah-Bacote, 1999). However, Drennan and Joseph (2005) suggest that creating a partnership in care with the health visitor and an asylum seeker who doesn't speak English can be compromised when the evidence suggests that health professionals often prioritise the physical needs of people above their emotional or mental health needs. It is

interesting to note that Briscoe and Lavender (2009) identify that health professionals can more clearly identify the client's care needs when they have gained real understanding of what asylum seekers have been through. For example, looking at photographs and field notes from where clients have come from can support and promote person-centred care interventions. According to Astbury et al (2017) person-centred is one of the core aspects of excellent health visiting practice – it is not an activity “done” to people rather it is about the person taking the lead. For health visitors, it involves helping people communicate what is important to them, giving them an informed choice, supporting them to get what they need, and ensuring they are in control of their own lives (Martin and Carey 2009).

Challenges in asylum seekers accessing services

Asylum seekers may find it difficult to talk openly and honestly about their experiences with a stranger, such as the health visitor, when they have been forced to flee their country of origin as a result of speaking out about their views and experiences (Tribe, 2007).

The health visitor's ability to build a relationship with asylum seekers can be complex and difficult due to the asylum seekers fears and lack of understanding about welfare and health systems within the UK. It can be difficult to explain how these systems function when people have nothing in their own countries with which to compare it (Perreira et al, 2012). The health visitor can explain, in simple language, the process of registering with a GP and dentist with potential help from family support workers and charitable organisations.

Continuity of health visiting services for asylum seeking families can be challenging as highlighted by Robertshaw et al (2017). Health visitors have identified that the

accommodation where asylum seekers are housed temporarily may be substandard and environmental factors, such as overcrowding and poorly maintained living accommodation, are key issues in barriers to care (Strang et al, 2018). Therefore, health visitors play a crucial role when undertaking a health needs assessment for asylum seekers, assessing their basic needs, such as living conditions, food and safety, before working on other needs, such as depression and isolation.

Also, research shows that these families rapidly change addresses (Drennan and Joseph, 2005). As a consequence, they often miss health visiting contacts due to frequent and often rapid moves. Obviously, this can be very time consuming for the health visitor when attempting to ensure continuity of care and it can have safeguarding implications when a family has not been seen due to them moving around the country. Importantly, this can severely hinder the development of sustaining, consistent therapeutic relationships between the health visitor and asylum seeking families.

Conclusion

The mental health needs of asylum seeking families are significant and complex. Asylum seeking families have difficulty in accessing and ensuring consistency of health care in the UK and health visitors are not always attuned to the multifactorial issues facing these families and may not have the capacity to deal with their mental health needs. It can be difficult for health visitors to overcome the language and cultural differences of asylum seeking families. Addressing their significant needs is a constant challenge.

However, positive influences should be acknowledged in order to ensure that individualised, optimum care can be provided. The literature suggests that child asylum seekers are at high risk of having mental health problems, but they also have the capacity to be resilient with timely support and clear signposting to relevant services.

In summary, this article expands the health visitor's knowledge and skills in providing culturally competent care that addresses the mental health needs of women and child asylum seekers. Strengthening the notion that health visitors need to take a holistic approach for both the assessment and care of asylum seeking families, there is the suggestion that, in order to fulfil their responsibilities, health visitors need greater understanding of the previous and possible ongoing traumas faced by these families. There is still a lot of stigma around mental health and this is intensified with asylum seekers who present with mental health issues, making it even harder for them to access services. It is therefore imperative that health visitors recognise their unique and crucial role in assessing, sign posting and planning care for these vulnerable families and improve their knowledge and understanding of the cultural complexities and emotional health needs of asylum seekers.

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